Alabama Medicaid Agency

All claims for uncompensated care must be received no later than June 30, 2006

Request for Reimbursement of Uncompensated Care

For Dates of Service Between August 24, 2005 through January 31, 2006

Notice to Providers

Claims up to the amount allocated for Alabama will be paid following the June 30, 2006 deadline.

Print or Type

Provider's Name	
Medicaid Provider Number	Federal Tax ID Number

Attach your spreadsheet containing the information specified in the Alabama Medicaid Agency Plan for Uncompensated Care.

PROVIDER CERTIFICATION

I certify that I have read the Alabama Medicaid Agency Plan for Uncompensated Care and I understand the requirement for the recipient to provide self attestation of lack of insurance coverage through any source or means to pay for medically necessary health care services. I also certify that: the services on the attached spread sheet were medically necessary; I have not received payment for these services from any other source; I will not subsequently bill any other source for these services; I am unaware of any other source of payment for these services; and I will accept payment under the Medicaid Plan for Uncompensated Care as payment in full for these services.

Signature of **either** the provider **or** his/her representative

Provider	Provider Representative
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

Provider Signature

Representative Signature

This form may be downloaded from the Alabama Medicaid Agency website: www.medicaid.state.al.us

Alabama Medicaid Agency Plan for Uncompensated Care

Uncompensated care shall mean Medically necessary services provided to an individual without private insurance, Medicaid in any state other than Louisiana or Mississippi, Medicare, health care vouchers from any state, federal, or charity organization, or any other method of health care coverage who was displaced as a result of hurricane Katrina.

Individual Assistance Designated Counties
By State for Hurricane Katrina

Louisiana:

Acadia, Ascension, Assumption, Calcasieu, Cameron, East Baton Rouge, East Feliciana, Iberia, Iberville, Jefferson, Jefferson Davis, Lafayette, Lafourche, Livingston, Orleans, Pointe Coupee, Plaquemines, St. Bernard, St. Charles, St. Helena, St. James, St. John, St. Mary, St. Martin, St. Tammany, Tangipahoa, Terrebonne, Vermilion, Washington, West Baton Rouge, and West Feliciana parishes.

Mississippi:

Adams, Amite, Attala, Claiborne, Choctaw, Clarke, Copiah, Covington, Forrest, Franklin, George, Greene, Hancock, Harrison, Hinds, Holmes, Humphries, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lamar, Lauderdale, Lawrence, Leake, Lincoln, Lowndes, Madison, Marion, Neshoba, Newton, Noxubee, Oktibbeha, Pearl River, Perry, Pike, Rankin, Scott, Simpson, Smith, Stone, Walthall, Warren, Wayne, Wilkinson, Winston, and Yazoo Counties.

Alabama:

Baldwin, Choctaw, Clarke, Greene, Hale, Marengo, Mobile, Pickens, Sumter, Tuscaloosa, and Washington Counties.

Florida:

As of March 1, 2006, no Florida counties have Individual Assistance Designation pursuant to Section 408.

Complete this form to request reimbursement for uncompensated care provided to Hurricane Katrina Evacuees. Attach an EXCEL spreadsheet containing the following information:

a. Recipient name
b. Home address (address from which individual has been displaced; county or parish and state). Provider may submit address of emergency shelter or disaster center for an individual prior to (date of approved plan).
c. Social security number (optional)
d. Date of Birth / Age
e. Sex
f. Self attestation from patient of no health care coverage through private insurance, Medicaid or SCHIP in any state, Medicare, health care vouchers from any state, federal, or charity organization, or any other method of health care coverage.
g. Service(s) rendered (by applicable billing code)
h. Charges for treatment
i. Date(s) of Service
j. Any other identifying data that would assist in establishing the recipient's identity in the absence of any of the items a-i above.

With respect for dental and eye care, reimbursement may only be made for a condition manifesting itself by acute symptoms. With respect to DME and supplies reimbursement may only be made for replacement equipment and supplies necessary for activities of daily living. Services and equipment requiring prior authorization will be reviewed and granted retroactively if the service/equipment meets Medicaid coverage guidelines.

Reimbursement of uncompensated care shall be limited to reimbursement for services covered through the Alabama Medicaid Program and in accordance with the terms of the Alabama Uncompensated Care Program.This form may be downloaded from the Alabama Medicaid Agency website: www.medicaid.state.al.us.

Mail To:
Alabama Medicaid Agency
System Support
501 Dexter Avenue
Montgomery, AL 36103